837 Health Care Claims/Encounters
Dental

Companion Transaction Specifications

Version 1.0

Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between DES and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the provider contracts or operational procedure manuals, the contract or procedure manual will prevail.

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837 Dental

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
N/A	REF	02	Transmission Type Code		Valid values are: Pilot Testing: 004010X097DA1 Production: 004010X097A1	Required
1000A	NM1	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification	Required
1000A	NM1	NM109	Submitter Identifier		CMDP Assigned Trading Partner ID	Required
1000B	NM1	NM103	Receiver Name		CMDP	Required
1000B	NM1	NM108	Identification Code Qualifier	46	Electronic Transmitter Identification Number (ETIN)	Required
1000B	NM1	NM109	Receiver Primary Identifier		C866004791	Required
2010AA	NM1	NM108	Identification Code Qualifier	24 or 34	Federal Taxpayer Identification Number	Required
2010AA	NM1	NM109	Billing Provider Identifier		Billing Provider's Federal Taxpayer Identification Number	Required
2010AA	REF	REF01	Reference Identification Qualifier	1D B3	Indicate 1D for Medicaid Provider Number	Required
2010AA	REF	REF02	Billing Provider Additional Identifier		Billing Provider's AHCCCS ID	Required
2010AB	NM1	NM108	Identification Code Qualifier	24 or 34	Federal Taxpayer Identification Number	Required
2010AB	NM1	NM109	Pay To Provider Identifier		Pay To Provider's Federal Taxpayer Identification Number Use Loop 2010 AB only when Pay To Provider is different from Billing Provider.	Required if applicable
2010AB	REF	REF01	Reference Identification Qualifier	1D B3	Indicate 1D for Medicaid Provider Number	Required if applicable
2010AB	REF	REF02	Pay To Provider Additional Identifier		Pay To Provider's AHCCCS ID	Required if applicable
2000B	SBR	SBR02	Individual Relationship Code	18	Self	Required

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
2000B	SBR	SBR09	Claim Filing Indicator Code	MC	Indicate MC for Medicaid	Required
2010BA	NM1	NM108	Identification Code Qualifier	MI	Member Identification Number	Required
2010BA	NM1	NM109	Subscriber Primary Identifier		Member's ID (As it appears on CMDP Identification Card)	Required
2010BB	NM1	NM103	Payer Name		CMDP	Required
2010BB	NM1	NM108	Identification Code Qualifier	PI	Payer Identification	Required
2010BB	NM1	NM109	Payer Identifier		C866004791	Required
2300	CLM	CLM01	Patient Account Number		This is the Patient Account Number used by the provider that performed the service. For HIPAA, the maximum length of the field is 20 characters.	Required
2300	CLM	CLM05-1	Facility Type Code		Place of Service can be submitted at the claim level. Place of Service Codes submitted at the claim level apply to all service lines unless overridden by a different Place of Service at the line level (SV105 in Loop 2400).	Required
2300	CLM	CLM05-3	Claim Frequency Code	1 7 8	Original Replacement (Replacement of prior claim) Void (Void/Cancel of prior claim)	Required
2300	CLM	CLM11-1 CLM11-2 CLM11-3	Related Causes Code	AA OA AP EM	Auto Accident Other Accident Another Party Responsible Employment CMDP requires one of these values if the situation it describes is present. Up to three Related Causes Codes can be submitted per claim (CLM11-1, CLM11-2, and	Required if applicable

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
					CLM11-03).	
2300	CLM	CLM11-4	Auto Accident State or Province Code	Standard 2 digit State/Province codes must be used where applicable	Required if any one of the Related Causes Code submitted has a value of “AA” (Auto Accident).	Required if applicable
2300	CLM	CLM11-5	Country Code	Standard 2 or 3 digit code identifying the country must be used where applicable	Required if any of the up to three Related Causes Code occurrences submitted has a value of “AA” (Auto Accident) and the accident occurred outside the United States.	Required if applicable
2300	CLM	CLM12	Special Program Indicator	01	Use this value for EPSDT examinations and screenings. Services that result from EPSDT referrals are indicated at the service line level by Element SV111 EPSDT Indicator in Loop 2400.	
2300	DTP	DTP01	Date Time Qualifier	439	Accident Date The Accident Date DTP Segment is required if the claim resulted from an accident (CLM11-1, -2, or -3 = “AA”, “OA” or “AP”).	Required if applicable
2300	DTP	DTP02	Date Time Period Format Qualifier	D8	Date expressed in format CCYYMMDD	Required if applicable
2300	DTP	DTP03	Accident Date		The date of the accident if the claim results from an accident (CLM11-1, -2 or -3 = “AA”, “OA” or “AP”).	Required if applicable
2300	REF	REF01	Reference Identification Qualifier	G1	Prior Authorization Number	Required if applicable
2300	REF	REF02	Prior Authorization Number		The Prior Authorization Number	Required if applicable

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
2300	REF	REF01	Reference Identification Qualifier	F8	Original Reference Number This REF Segment is required if a claim voids or replaces another claim.	
2300	REF	REF02	Claim Original Reference Number		For replacement and void claims (CLM05-3 = “7” or “8”), the AHCCCS Claim Reference Number (CRN) of the prior claim being replaced or voided.	
2310A	NM1	NM108	Identification Code Qualifier	24 34	Employer’s Identification Number Social Security Number Use the 2310A Loop when a referring provider is present at the claim level If a referring provider exists, CMDP will need to be provided the information at the claim level and not at the claim detail level	Required if applicable
2310A	NM1	NM109	Referring Provider Identifier		The referring provider’s Federal Tax ID or Social Security Number.	Required if applicable
2310A	REF	REF01	Reference Identification Qualifier	1D B3	Indicate 1D for Medicaid Provider Number	Required if applicable
2310A	REF	REF02	Referring Provider Secondary Identifier		Provider’s AHCCCS ID	Required if applicable
2310B	NM1	NM108	Identification Code Qualifier	24 or 34	Employer’s Identification Number or Social Security Number Use the 2310B Loop for the rendering provider at the claim level when the rendering provider is different from the billing provider in Loop 2010AA. If billing and rendering providers are the same, the 2310B Loop is not needed. Although the 837 Transaction supports different Rendering Providers at the service line level, CMDP policy requires a single	Required if rendering provider is different from billing provider

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
					Rendering Provider per claim.	
2310B	NM1	NM109	Rendering Provider Identifier		The rendering provider's Federal Tax ID or Social Security Number	Required if rendering provider is different from billing provider
2310B	REF	REF01	Reference Identification Qualifier	1D B3	Indicate 1D for Medicaid Provider Number	Required if rendering provider is different from billing provider
2310B	REF	REF02	Rendering Provider Secondary Identifier		Provider's AHCCCS ID	Required if rendering provider is different from billing provider
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	P S T	Primary Secondary Tertiary Other carrier Loop 2320 can occur up to ten times for up to ten payers other than CMDP	Required if applicable
2320	SBR	SBR03	Insured Group or Policy Number		A Group or Policy Number associated with the other coverage.	Required if applicable
2320	SBR	SBR04	Policy Name		A Group or Policy Name associated with SBR03	Required if applicable
2400	LX	LX01	Assigned Number		The number of the service line beginning with 1 for the first line For Dental Claims the number of lines should not exceed 50 (per the Implementation Guide	Required
2400	SV3	SV301-1	Product or Service ID Qualifier	AD	American Dental Association Code CDT (Current Dental Terminology)	Required

Loop ID	Segment ID	Element ID	Element Name	Valid Values	Definition/Format CMDP	Usage
2400	SV3	SV301-2	Procedure Code		CDT Code	
2400	SV1	SV301-3-SV301-6	Procedure Modifier		According to the 837 Dental Addenda, Dental Procedure Code Modifiers must be valid ADA Procedure Code Modifiers.	Required if applicable
2400	SV3	SV304-1 – SV304-5	Oral Cavity Designation Code		Quadrants are now submitted as Oral Cavity Designation codes with code values listed in the 837 Dental Implementation Guide	Required if applicable
2400	SV3	SV306	Procedure Count		Number of units without decimal points	Required
2400	TOO	TOO01	Code List Qualifier	JP	National Standard Tooth Numbering System	Required if applicable
2400	TOO	TOO02	Tooth Number		The ADA code for Tooth Number affected by the surface or surfaces Although up to 32 occurrences of Tooth Number can be submitted per dental service line only a single occurrence is used by CMDP.	Required if applicable
2400	TOO	TOO03-1-TOO03-5	Tooth Surface		The 837 Dental Transactions can accommodate up to 5 occurrences of Tooth Surface Codes in association with each tooth number	Required if applicable
2400	REF	REF01	Reference Identification Qualifier	G1	The Prior Authorization number assigned by CMDP for the service listed on the claim. Use this segment when the prior authorization is at the service level rather than at the claim level	Required if applicable